Patient History Form

Patient Name: _____ MRN: _____

Patient Phone: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Referring Physician

Name: _____

Address: _____

_____

Phone: _____

Primary Care Physician

Name: _____

Address: _____

_____

Phone: _____

Please describe the problem and your symptoms: _____

_____

_____

_____

_____

Please list all medical conditions and hospitalizations you have ever had (including dates):

_____

_____

_____

_____

Please list all surgeries and procedures you have ever had (including dates):

_____

_____

_____

_____

Please describe any known allergies: _____

_____

_____

_____

_____

Has anyone in your family ever had cancer? ☐No ☐Yes- who and what type?

_____

_____

_____

Any other family medical problems? _____

_____

_____

Do you use tobacco products? ☐No ☐Yes

Continue on back if necessary

Patient History Form, cont.

Which type, how often and for how long? _____

Do you consume alcohol? ☐No ☐Yes
Approximately how much per day? _____

Marital Status: _____How many children? _____

Are you working? ☐No ☐Yes
Occupation? _____

Please list all medications or supplements you are taking:

Drug or Supplement Name	Dose	Frequency

Continue on back if necessary